
ENGROSSED SUBSTITUTE SENATE BILL 6538

State of Washington

61st Legislature

2010 Regular Session

By Senate Health & Long-Term Care (originally sponsored by Senators Keiser and Pflug)

READ FIRST TIME 02/05/10.

1 AN ACT Relating to the definition of small groups for insurance
2 purposes; amending RCW 48.43.035; reenacting and amending RCW
3 48.43.005; and creating a new section.

4 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

5 **Sec. 1.** RCW 48.43.005 and 2008 c 145 s 20 and 2008 c 144 s 1 are
6 each reenacted and amended to read as follows:

7 Unless otherwise specifically provided, the definitions in this
8 section apply throughout this chapter.

9 (1) "Adjusted community rate" means the rating method used to
10 establish the premium for health plans adjusted to reflect actuarially
11 demonstrated differences in utilization or cost attributable to
12 geographic region, age, family size, and use of wellness activities.

13 (2) "Basic health plan" means the plan described under chapter
14 70.47 RCW, as revised from time to time.

15 (3) "Basic health plan model plan" means a health plan as required
16 in RCW 70.47.060(2)(e).

17 (4) "Basic health plan services" means that schedule of covered
18 health services, including the description of how those benefits are to

1 be administered, that are required to be delivered to an enrollee under
2 the basic health plan, as revised from time to time.

3 (5) "Catastrophic health plan" means:

4 (a) In the case of a contract, agreement, or policy covering a
5 single enrollee, a health benefit plan requiring a calendar year
6 deductible of, at a minimum, one thousand seven hundred fifty dollars
7 and an annual out-of-pocket expense required to be paid under the plan
8 (other than for premiums) for covered benefits of at least three
9 thousand five hundred dollars, both amounts to be adjusted annually by
10 the insurance commissioner; and

11 (b) In the case of a contract, agreement, or policy covering more
12 than one enrollee, a health benefit plan requiring a calendar year
13 deductible of, at a minimum, three thousand five hundred dollars and an
14 annual out-of-pocket expense required to be paid under the plan (other
15 than for premiums) for covered benefits of at least six thousand
16 dollars, both amounts to be adjusted annually by the insurance
17 commissioner; or

18 (c) Any health benefit plan that provides benefits for hospital
19 inpatient and outpatient services, professional and prescription drugs
20 provided in conjunction with such hospital inpatient and outpatient
21 services, and excludes or substantially limits outpatient physician
22 services and those services usually provided in an office setting.

23 In July 2008, and in each July thereafter, the insurance
24 commissioner shall adjust the minimum deductible and out-of-pocket
25 expense required for a plan to qualify as a catastrophic plan to
26 reflect the percentage change in the consumer price index for medical
27 care for a preceding twelve months, as determined by the United States
28 department of labor. The adjusted amount shall apply on the following
29 January 1st.

30 (6) "Certification" means a determination by a review organization
31 that an admission, extension of stay, or other health care service or
32 procedure has been reviewed and, based on the information provided,
33 meets the clinical requirements for medical necessity, appropriateness,
34 level of care, or effectiveness under the auspices of the applicable
35 health benefit plan.

36 (7) "Concurrent review" means utilization review conducted during
37 a patient's hospital stay or course of treatment.

1 (8) "Covered person" or "enrollee" means a person covered by a
2 health plan including an enrollee, subscriber, policyholder,
3 beneficiary of a group plan, or individual covered by any other health
4 plan.

5 (9) "Dependent" means, at a minimum, the enrollee's legal spouse
6 and unmarried dependent children who qualify for coverage under the
7 enrollee's health benefit plan.

8 (10) "Employee" has the same meaning given to the term, as of
9 January 1, 2008, under section 3(6) of the federal employee retirement
10 income security act of 1974.

11 (11) "Emergency medical condition" means the emergent and acute
12 onset of a symptom or symptoms, including severe pain, that would lead
13 a prudent layperson acting reasonably to believe that a health
14 condition exists that requires immediate medical attention, if failure
15 to provide medical attention would result in serious impairment to
16 bodily functions or serious dysfunction of a bodily organ or part, or
17 would place the person's health in serious jeopardy.

18 (12) "Emergency services" means otherwise covered health care
19 services medically necessary to evaluate and treat an emergency medical
20 condition, provided in a hospital emergency department.

21 (13) "Enrollee point-of-service cost-sharing" means amounts paid to
22 health carriers directly providing services, health care providers, or
23 health care facilities by enrollees and may include copayments,
24 coinsurance, or deductibles.

25 (14) "Grievance" means a written complaint submitted by or on
26 behalf of a covered person regarding: (a) Denial of payment for
27 medical services or nonprovision of medical services included in the
28 covered person's health benefit plan, or (b) service delivery issues
29 other than denial of payment for medical services or nonprovision of
30 medical services, including dissatisfaction with medical care, waiting
31 time for medical services, provider or staff attitude or demeanor, or
32 dissatisfaction with service provided by the health carrier.

33 (15) "Health care facility" or "facility" means hospices licensed
34 under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW,
35 rural health care facilities as defined in RCW 70.175.020, psychiatric
36 hospitals licensed under chapter 71.12 RCW, nursing homes licensed
37 under chapter 18.51 RCW, community mental health centers licensed under
38 chapter 71.05 or 71.24 RCW, kidney disease treatment centers licensed

1 under chapter 70.41 RCW, ambulatory diagnostic, treatment, or surgical
2 facilities licensed under chapter 70.41 RCW, drug and alcohol treatment
3 facilities licensed under chapter 70.96A RCW, and home health agencies
4 licensed under chapter 70.127 RCW, and includes such facilities if
5 owned and operated by a political subdivision or instrumentality of the
6 state and such other facilities as required by federal law and
7 implementing regulations.

8 (16) "Health care provider" or "provider" means:

9 (a) A person regulated under Title 18 or chapter 70.127 RCW, to
10 practice health or health-related services or otherwise practicing
11 health care services in this state consistent with state law; or

12 (b) An employee or agent of a person described in (a) of this
13 subsection, acting in the course and scope of his or her employment.

14 (17) "Health care service" means that service offered or provided
15 by health care facilities and health care providers relating to the
16 prevention, cure, or treatment of illness, injury, or disease.

17 (18) "Health carrier" or "carrier" means a disability insurer
18 regulated under chapter 48.20 or 48.21 RCW, a health care service
19 contractor as defined in RCW 48.44.010, or a health maintenance
20 organization as defined in RCW 48.46.020.

21 (19) "Health plan" or "health benefit plan" means any policy,
22 contract, or agreement offered by a health carrier to provide, arrange,
23 reimburse, or pay for health care services except the following:

24 (a) Long-term care insurance governed by chapter 48.84 or 48.83
25 RCW;

26 (b) Medicare supplemental health insurance governed by chapter
27 48.66 RCW;

28 (c) Coverage supplemental to the coverage provided under chapter
29 55, Title 10, United States Code;

30 (d) Limited health care services offered by limited health care
31 service contractors in accordance with RCW 48.44.035;

32 (e) Disability income;

33 (f) Coverage incidental to a property/casualty liability insurance
34 policy such as automobile personal injury protection coverage and
35 homeowner guest medical;

36 (g) Workers' compensation coverage;

37 (h) Accident only coverage;

1 (i) Specified disease or illness-triggered fixed payment insurance,
2 hospital confinement fixed payment insurance, or other fixed payment
3 insurance offered as an independent, noncoordinated benefit;

4 (j) Employer-sponsored self-funded health plans;

5 (k) Dental only and vision only coverage; and

6 (l) Plans deemed by the insurance commissioner to have a short-term
7 limited purpose or duration, or to be a student-only plan that is
8 guaranteed renewable while the covered person is enrolled as a regular
9 full-time undergraduate or graduate student at an accredited higher
10 education institution, after a written request for such classification
11 by the carrier and subsequent written approval by the insurance
12 commissioner.

13 (20) "Material modification" means a change in the actuarial value
14 of the health plan as modified of more than five percent but less than
15 fifteen percent.

16 (21) "Preexisting condition" means any medical condition, illness,
17 or injury that existed any time prior to the effective date of
18 coverage.

19 (22) "Premium" means all sums charged, received, or deposited by a
20 health carrier as consideration for a health plan or the continuance of
21 a health plan. Any assessment or any "membership," "policy,"
22 "contract," "service," or similar fee or charge made by a health
23 carrier in consideration for a health plan is deemed part of the
24 premium. "Premium" shall not include amounts paid as enrollee point-
25 of-service cost-sharing.

26 (23) "Review organization" means a disability insurer regulated
27 under chapter 48.20 or 48.21 RCW, health care service contractor as
28 defined in RCW 48.44.010, or health maintenance organization as defined
29 in RCW 48.46.020, and entities affiliated with, under contract with, or
30 acting on behalf of a health carrier to perform a utilization review.

31 (24) "Small employer" or "small group" means any person, firm,
32 corporation, partnership, association, political subdivision, sole
33 proprietor, or self-employed individual that is actively engaged in
34 business that employed an average of at least (~~two~~) one but no more
35 than fifty employees, during the previous calendar year and employed at
36 least (~~two~~) one employee(~~s~~) on the first day of the plan year, is
37 not formed primarily for purposes of buying health insurance, and in
38 which a bona fide employer-employee relationship exists. In

1 determining the number of employees, companies that are affiliated
2 companies, or that are eligible to file a combined tax return for
3 purposes of taxation by this state, shall be considered an employer.
4 Subsequent to the issuance of a health plan to a small employer and for
5 the purpose of determining eligibility, the size of a small employer
6 shall be determined annually. Except as otherwise specifically
7 provided, a small employer shall continue to be considered a small
8 employer until the plan anniversary following the date the small
9 employer no longer meets the requirements of this definition. A self-
10 employed individual or sole proprietor (~~((who is covered as a group of
11 one on the day prior to June 10, 2004, shall also be considered a
12 "small employer" to the extent that individual or group of one is
13 entitled to have his or her coverage renewed as provided in RCW
14 48.43.035(6))~~) who is covered as a group of one must also: (a) Have
15 been employed by the same small employer or small group for at least
16 twelve months prior to application for small group coverage, and (b)
17 verify that he or she derived at least seventy-five percent of his or
18 her income from a trade or business through which the individual or
19 sole proprietor has attempted to earn taxable income and for which he
20 or she has filed the appropriate internal revenue service form 1040,
21 schedule C or F, for the previous taxable year, except a self-employed
22 individual or sole proprietor in an agricultural trade or business,
23 must have derived at least fifty-one percent of his or her income from
24 the trade or business through which the individual or sole proprietor
25 has attempted to earn taxable income and for which he or she has filed
26 the appropriate internal revenue service form 1040, for the previous
27 taxable year.

28 (25) "Utilization review" means the prospective, concurrent, or
29 retrospective assessment of the necessity and appropriateness of the
30 allocation of health care resources and services of a provider or
31 facility, given or proposed to be given to an enrollee or group of
32 enrollees.

33 (26) "Wellness activity" means an explicit program of an activity
34 consistent with department of health guidelines, such as, smoking
35 cessation, injury and accident prevention, reduction of alcohol misuse,
36 appropriate weight reduction, exercise, automobile and motorcycle
37 safety, blood cholesterol reduction, and nutrition education for the

1 purpose of improving enrollee health status and reducing health service
2 costs.

3 **Sec. 2.** RCW 48.43.035 and 2004 c 244 s 4 are each amended to read
4 as follows:

5 For group health benefit plans, the following shall apply:

6 (1) All health carriers shall accept for enrollment any state
7 resident within the group to whom the plan is offered and within the
8 carrier's service area and provide or assure the provision of all
9 covered services regardless of age, sex, family structure, ethnicity,
10 race, health condition, geographic location, employment status,
11 socioeconomic status, other condition or situation, or the provisions
12 of RCW 49.60.174(2). The insurance commissioner may grant a temporary
13 exemption from this subsection, if, upon application by a health
14 carrier the commissioner finds that the clinical, financial, or
15 administrative capacity to serve existing enrollees will be impaired if
16 a health carrier is required to continue enrollment of additional
17 eligible individuals.

18 (2) Except as provided in subsection (5) of this section, all
19 health plans shall contain or incorporate by endorsement a guarantee of
20 the continuity of coverage of the plan. For the purposes of this
21 section, a plan is "renewed" when it is continued beyond the earliest
22 date upon which, at the carrier's sole option, the plan could have been
23 terminated for other than nonpayment of premium. The carrier may
24 consider the group's anniversary date as the renewal date for purposes
25 of complying with the provisions of this section.

26 (3) The guarantee of continuity of coverage required in health
27 plans shall not prevent a carrier from canceling or nonrenewing a
28 health plan for:

29 (a) Nonpayment of premium;

30 (b) Violation of published policies of the carrier approved by the
31 insurance commissioner;

32 (c) Covered persons entitled to become eligible for medicare
33 benefits by reason of age who fail to apply for a medicare supplement
34 plan or medicare cost, risk, or other plan offered by the carrier
35 pursuant to federal laws and regulations;

36 (d) Covered persons who fail to pay any deductible or copayment

1 amount owed to the carrier and not the provider of health care
2 services;

3 (e) Covered persons committing fraudulent acts as to the carrier;

4 (f) Covered persons who materially breach the health plan; or

5 (g) Change or implementation of federal or state laws that no
6 longer permit the continued offering of such coverage.

7 (4) The provisions of this section do not apply in the following
8 cases:

9 (a) A carrier has zero enrollment on a product;

10 (b) A carrier replaces a product and the replacement product is
11 provided to all covered persons within that class or line of business,
12 includes all of the services covered under the replaced product, and
13 does not significantly limit access to the kind of services covered
14 under the replaced product. The health plan may also allow
15 unrestricted conversion to a fully comparable product;

16 (c) No sooner than January 1, 2005, a carrier discontinues offering
17 a particular type of health benefit plan offered for groups of up to
18 two hundred if: (i) The carrier provides notice to each group of the
19 discontinuation at least ninety days prior to the date of the
20 discontinuation; (ii) the carrier offers to each group provided
21 coverage of this type the option to enroll, with regard to small
22 employer groups, in any other small employer group plan, or with regard
23 to groups of up to two hundred, in any other applicable group plan,
24 currently being offered by the carrier in the applicable group market;
25 and (iii) in exercising the option to discontinue coverage of this type
26 and in offering the option of coverage under (c)(ii) of this
27 subsection, the carrier acts uniformly without regard to any health
28 status-related factor of enrolled individuals or individuals who may
29 become eligible for this coverage;

30 (d) A carrier discontinues offering all health coverage in the
31 small group market or for groups of up to two hundred, or both markets,
32 in the state and discontinues coverage under all existing group health
33 benefit plans in the applicable market involved if: (i) The carrier
34 provides notice to the commissioner of its intent to discontinue
35 offering all such coverage in the state and its intent to discontinue
36 coverage under all such existing health benefit plans at least one
37 hundred eighty days prior to the date of the discontinuation of
38 coverage under all such existing health benefit plans; and (ii) the

1 carrier provides notice to each covered group of the intent to
2 discontinue the existing health benefit plan at least one hundred
3 eighty days prior to the date of discontinuation. In the case of
4 discontinuation under this subsection, the carrier may not issue any
5 group health coverage in this state in the applicable group market
6 involved for a five-year period beginning on the date of the
7 discontinuation of the last health benefit plan not so renewed. This
8 subsection (4) does not require a carrier to provide notice to the
9 commissioner of its intent to discontinue offering a health benefit
10 plan to new applicants when the carrier does not discontinue coverage
11 of existing enrollees under that health benefit plan; or

12 (e) A carrier is withdrawing from a service area or from a segment
13 of its service area because the carrier has demonstrated to the
14 insurance commissioner that the carrier's clinical, financial, or
15 administrative capacity to serve enrollees would be exceeded.

16 (5) The provisions of this section do not apply to health plans
17 deemed by the insurance commissioner to be unique or limited or have a
18 short-term purpose, after a written request for such classification by
19 the carrier and subsequent written approval by the insurance
20 commissioner.

21 ~~((6) Notwithstanding any other provision of this section, the~~
22 ~~guarantee of continuity of coverage applies to a group of one only if:~~
23 ~~(a) The carrier continues to offer any other small employer group plan~~
24 ~~in which the group of one was eligible to enroll on the day prior to~~
25 ~~June 10, 2004; and (b) the person continues to qualify as a group of~~
26 ~~one under the criteria in place on the day prior to June 10, 2004.))~~

27 NEW SECTION. **Sec. 3.** This act applies to small group policies
28 issued or renewed on or after January 1, 2011.

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